

Small Cell Lung Cancer (SCLC) Radiation Therapy Treatment Plan Checklist

1/01/2015

NIA has provided this checklist to assist you in gathering the clinical and treatment plan information needed to request a medical necessity review. The most efficient way to submit a review request is via www.RadMD.com or call the NIA Call Center toll free number.

Please **do not fax** the checklist to NIA.

General Information			
Patient Name :		DOB:	Health Plan ID :
Radiation Oncologist :		Radiation Therapy Facility :	
Treatment Planning Start Date (i.e. Initial Simulation) :		Anticipated Treatment Start Date :	
Patient Clinical Information			
T Stage: <input type="checkbox"/> TX <input type="checkbox"/> T0 <input type="checkbox"/> Tis <input type="checkbox"/> T1 <input type="checkbox"/> T2 <input type="checkbox"/> T3 <input type="checkbox"/> T4	N Stage: <input type="checkbox"/> NX <input type="checkbox"/> N0 <input type="checkbox"/> N1 <input type="checkbox"/> N2 <input type="checkbox"/> N3 Does patient have distant metastasis (M1)? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Cancer Stage: <input type="checkbox"/> Limited <input type="checkbox"/> Extensive <input checked="" type="checkbox"/> Treatment Intent : <input type="checkbox"/> Curative <input type="checkbox"/> Palliative <input checked="" type="checkbox"/> If palliative, what is the reason for radiation therapy? (e.g. airway obstruction, hemoptysis pain, etc.) <input checked="" type="checkbox"/> Is chemotherapy planned : <input type="checkbox"/> Yes <input type="checkbox"/> No	
Treatment Planning Information			
<input checked="" type="checkbox"/> What is the prescription radiation dose for the <u>ENTIRE</u> course of external beam treatment?			Gy
Initial Treatment Phase - Select Therapy			
<input type="checkbox"/> 2-Dimension <input checked="" type="checkbox"/> Fractions : _____			
<input type="checkbox"/> 3D Conformal <input checked="" type="checkbox"/> Number of ports/arcs/fields: _____			
<input type="checkbox"/> IMRT <input checked="" type="checkbox"/> Will any of the following take place during the simulation: custom device created, contrast utilized or custom blocking determined? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<div style="border: 1px solid black; padding: 2px;"> IMRT Only <input checked="" type="checkbox"/> Which technique will be used? <input type="checkbox"/> Linac Multi-Angle <input type="checkbox"/> Compensator-Based <input type="checkbox"/> Helical <input type="checkbox"/> Arc Therapy <input type="checkbox"/> Other <input checked="" type="checkbox"/> Will techniques to account for respiratory motion be performed? <input type="checkbox"/> Yes <input type="checkbox"/> No </div>			
<i>Note: IMRT treatment requests will be reviewed for medical necessity by a radiation oncologist. Clinical rationale for performing IMRT is required and should include a comparison 3D-CRT plan and tissue constraints and target goals of the plan. Field in field or forward planning is not considered IMRT.</i>			
<input type="checkbox"/> SBRT <input checked="" type="checkbox"/> Number of ports/arcs/fields: _____ <input checked="" type="checkbox"/> Fractions : _____ <input checked="" type="checkbox"/> Which technique will be used? <input type="checkbox"/> Robotic -Linac Multi-Angle <input type="checkbox"/> Robotic- Tomotherapy <input type="checkbox"/> Robotic -Cyberknife <input type="checkbox"/> Non -Robotic			
<input type="checkbox"/> High Dose Rate (HDR) Brachytherapy <input checked="" type="checkbox"/> Fractions: _____ <input checked="" type="checkbox"/> Will a tumor volume and at least one critical structure be contoured for brachytherapy planning? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Image Guidance (IGRT) Technique <input type="checkbox"/> None (select none for port films) <input type="checkbox"/> CT Guidance (Conebeam CT) <input type="checkbox"/> Stereoscopic Guidance (kV or mV with fiducial markers) <input type="checkbox"/> Other _____			
<input checked="" type="checkbox"/> At what frequency will the IGRT be performed? <input type="checkbox"/> Daily <input type="checkbox"/> 1 time per week <input type="checkbox"/> Other _____			

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PCI Phase (if needed)	
<input type="checkbox"/> Prophylactic Cranial Irradiation (PCI)	
✓ Total PCI Dose (Gy) : _____	✓ Number of ports/fields: _____
✓ Fractions : _____	✓ What is the type of PCI performed? <input type="checkbox"/> 2D <input type="checkbox"/> 3D <input type="checkbox"/> Other

Boost Phase 1 - Select Therapy	
<input type="checkbox"/> 2-Dimension	✓ Fractions : _____
<input type="checkbox"/> 3D Conformal	✓ Number of ports/arcs/fields: _____
<input type="checkbox"/> IMRT	✓ Will a new CT be performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
IMRT Only	✓ Which technique will be used? <input type="checkbox"/> Linac Multi-Angle <input type="checkbox"/> Compensator-Based <input type="checkbox"/> Helical <input type="checkbox"/> Arc Therapy <input type="checkbox"/> Other
	✓ Will techniques to account for respiratory motion be performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Image Guidance (IGRT) Technique:	
<input type="checkbox"/> None (select none for port films)	<input type="checkbox"/> CT Guidance (Conebeam CT)
<input type="checkbox"/> Stereoscopic Guidance (kV or mV with fiducial markers)	<input type="checkbox"/> Other _____
✓ At what frequency will the IGRT be performed? <input type="checkbox"/> Daily <input type="checkbox"/> 1 time per week <input type="checkbox"/> Other _____	

Boost Phase 2 - Select Therapy	
<input type="checkbox"/> 2-Dimension	✓ Fractions : _____
<input type="checkbox"/> 3D Conformal	✓ Number of ports/arcs/fields: _____
<input type="checkbox"/> IMRT	✓ Will a new CT be performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
IMRT Only	✓ Which technique will be used? <input type="checkbox"/> Linac Multi-Angle <input type="checkbox"/> Compensator-Based <input type="checkbox"/> Helical <input type="checkbox"/> Arc Therapy <input type="checkbox"/> Other
	✓ Will techniques to account for respiratory motion be performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Image Guidance (IGRT) Technique:	
<input type="checkbox"/> None (select none for port films)	<input type="checkbox"/> CT Guidance (Conebeam CT)
<input type="checkbox"/> Stereoscopic Guidance (kV or mV with fiducial markers)	<input type="checkbox"/> Other _____
✓ At what frequency will the IGRT be performed? <input type="checkbox"/> Daily <input type="checkbox"/> 1 time per week <input type="checkbox"/> Other _____	

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Special Services – Please note if you are faxing additional information
<input type="checkbox"/> Special Dosimetry (CPT® 77331) Provide requested quantity and the rationale for performing the service.
<input type="checkbox"/> Special Physics Consultation (CPT® 77370) Provide the rationale for performing the service.
<input type="checkbox"/> Special Treatment Procedure (CPT® 77470) Provide the rationale for performing the service.